

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
54	n. Self-Administration of drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe.	(M) Met					
55	<p>§ 51.80 Admission, transfer and discharge rights.</p> <p>a. Transfer and discharge:</p> <p>1. Definition. Transfer and discharge includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility.</p> <p>2. Transfer and discharge requirements. The facility management must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:</p> <p>i. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home;</p> <p>ii. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home;</p> <p>iii. The safety of individuals in the facility is endangered;</p> <p>iv. The health of individuals in the facility would otherwise be endangered;</p> <p>v. The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility; or</p> <p>vi. The nursing home ceases to operate.</p>	(P) Provisional Met	<p>Based on record review and interview the facility failed to complete transfer documentation for two un-sampled residents who were transferred to an acute care facility. Documentation including the physician decision to transfer, the date, time and details of the transfer were not documented in the medical record. The findings include:</p> <p>Record review</p> <p>1. Un-sampled Resident #1 was admitted to the facility on 1/18/2011 with diagnoses including Paranoid Schizophrenia, Cognitive impairment, Congestive Heart Failure and Hypertension. The Resident was transferred to an acute care hospital on 3/7/2011. A review of the record revealed no documentation describing the clinical reason, decision, or any details for the transfer had been documented.</p> <p>2. Un-sampled Resident #2 was admitted to the facility on 2/7/2002 with diagnoses including Heart Disease, Hearing Loss, and Organic Brain Syndrome. The Resident was transferred to an acute care hospital on 3/21/2011. A review of the record revealed no documentation describing the clinical reason, decision, or any details for the transfer had been documented.</p> <p>Interview</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 3/31/2011 at 11:00 am, the ADON acknowledged that a transfer sheet must be completed whenever a transfer occurs. The ADON stated "Our transfer sheet is called a Nursing Referral and I don't know why one was not filled out for these transfers".</p> <p>S/S=D</p>	<p>a. Un-sampled members 1 & 2 charts contained clinical information provided by the physician for decision of reason of transfer to hospital</p> <p>b. Members with a change of condition will have a Physician Notification Form completed for Doctor notification. If the Doctor makes the decision to transfer to hospital, a transfer form will be completed with the clinical information stating member's condition. A copy of the transfer form will be filed in the member's medical record.</p> <p>c. Licensed nurses were educated on the new Physician Notification Form on 04/18/2011 and 04/20/2011 and will be educated on new Transfer Form on 05/11/2011 and 05/12/2011.</p> <p>d. After education and training the ADONs and Nurse Supervisor will complete audits of every transfer form for completeness of clinical reason for 3 months. Data will be brought to QA for review and revision. DON or designee will monitor process to assure correction.</p> <p>e. Completed by 05/16/2011</p>			

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61	<p>b. Notice of bed-hold policy and readmission.</p> <p>1. Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility management must provide written information to the resident and a family member or legal representative that specifies:</p> <p>i. The duration of the facility's bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; and</p> <p>ii. The facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section permitting a resident to return.</p> <p>2. Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>3. Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room. If the resident required the services provided by the facility.</p>	(P) Provisional Met	<p>Based on record review, interview and policy review, the facility failed to ensure that three Residents (Resident #1, and two un-sampled Residents) were presented written information about the facility's bed-hold policy before being transferred out of the facility. No documentation noting that the Resident, and a family member or legal representative were provided with notice of the facility's bed-hold policy before these Residents were transferred to an acute care hospital could be found in the medical record. The findings include:</p> <p>Record review</p> <p>1. Resident #1 was admitted to the facility on 5/11/2010 with diagnoses including Heart Disease, Congestive Heart Failure, and Esophageal Reflux. The Resident was transferred to an acute care hospital on 3/30/2011. A review of the medical record revealed no documentation that the Resident and a family member or legal representative was provided with information on the facility's bed-hold policy prior to transfer.</p> <p>2. Un-sampled Resident #1 was admitted to the facility on 1/18/2011 with diagnoses including Paranoid Schizophrenia, Cognitive Impairment, Congestive Heart Failure and Hypertension. The Resident was transferred to an acute care hospital on 3/7/2011. A review of the medical record revealed no documentation that the Resident and a family member or legal representative was provided with information on the facility's bed-hold policy prior to transfer.</p> <p>3. Un-sampled Resident #2 was admitted to the facility on 2/7/2002 with diagnoses including Heart Disease, hearing loss, and Organic Brain Syndrome. The Resident was transferred to an acute care hospital on 3/21/2011. A review of the medical record revealed no documentation that the Resident and a family member or legal representative was provided with information on the facility's bed-hold policy prior to transfer.</p>	<p>a. Member #1 and un-sampled member 1 & 2 bed hold notification were sent to their legal representative.</p> <p>b. For members requiring a bed hold notification, at time of transfer a verbal notification will be given to member and legal representative by licensed nurse. Social Worker will mail out written notice of bed hold notification to legal representative and give the member a copy and a copy will be placed in the member's medical record.</p> <p>c. Licensed nurses and Social Workers will be trained on the Bed Hold Policy and Procedure by 05/11/2011 and 05/12/2011.</p> <p>d. After education and training the Social Worker, ADONs, and Nursing Supervisor will complete audits to assure completeness of bed hold process. Audits will be completed the next business day after the transfer & continue for 3 months. Data will be taken to QA for review and revision. QA coordinator will monitor process.</p> <p>e. Completed by 05/16/2011</p>			

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			<p>Interview An interview was conducted with the Assistant Director of Nursing (ADON) on 3/30/2011 at 11:30 am. The ADON stated "Our policy requires that we inform the Resident and a family member at the time of transfer of our bed-hold policy. We document that we informed the Resident on the Nursing Referral form. The ADON could not explain why this form was not found in the medical record.</p> <p>Policy review The facility's policy titled "Bed Hold Policy", reviewed date October 9, 2009, and indicates the following: "Procedure: 5. nursing personnel will review the bed hold policy with the member/POA (Power of Attorney)/Guardian prior to transfer to an acute care setting. This will be documented on the "Nursing Referral Form" or the "Transfer Sheet". S/S=D</p>				
62	c. Equal access to quality care. The facility management must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment.	(M) Met					
63	d. Admissions policy. The facility management must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual	(M) Met					

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109	<p>j. Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident:</p> <ol style="list-style-type: none"> 1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 2. Receives a therapeutic diet when a nutritional deficiency is identified. 	(P) Provisional Met	<p>Based on record review, interview and policy review, the facility failed to follow Resident #1 for unplanned weight loss. Resident #1 experienced a 14 pound weight loss in two weeks that was not assessed.</p> <p>The findings include:</p> <p>Record review</p> <p>Resident #1 was admitted to the facility on 5/11/2010 with diagnoses including Heart Disease, Congestive Heart Failure, and Esophageal Reflux.</p> <p>Review of Resident #1's weight record revealed the following:</p> <p>3/15/2011 – 172.4 pounds 3/22/2011 – 164.0 pounds 3/25/2011 – 165.8 pounds 3/29/2011 – 159.8 pounds</p> <p>A review of the Physician Notes revealed a note was written on 3/16/2011 and 3/21/2011. These notes contained no documentation that a weight loss had been reported to the physician.</p> <p>Nutrition Screen/Assessment on 3/3/2011 documented the following: "New weights 2/13/11: 175.4 lbs; 2/18/11: 188.6 lbs re weigh 188.6 to 185.8 lbs. 2/25/11: refused. Question correctness of last weight".</p> <p>A review of the Nurse's Notes from 3/15/2011 through 3/29/2011 indicated no documentation that the physician or the registered dietician had been notified of weight loss. A Nurse's Note written on 3/29/2011 at 2:00 pm indicated "Dr. notified of weight loss".</p> <p>Review of "Food Intake Record" revealed:</p> <p>3/15/2011 – Breakfast 25%, Lunch 25%, Dinner 25% 3/16/2011 – Breakfast 25%, Lunch 25%, Dinner 50% 3/17/2011 – Breakfast 25%, Lunch 50%, Dinner 50% 3/18/2011 – Breakfast 50%, Lunch 25%, Dinner 25% 3/19/2011 – Breakfast 75%, Lunch 50%, Dinner 50% 3/20/2011 – Breakfast 50%, Lunch 0%, Dinner 25% 3/21/2011 – Breakfast 25%, Lunch 0%, Dinner 100% 3/22/2011 – Breakfast 50%, Lunch 50%,</p>	<ol style="list-style-type: none"> a. Member #1 has been assessed by Registered Dietitian with Doctor notified of findings and recommendations. b. Members will be weighed weekly and reviewed by RD. When an unplanned weight loss is identified, RD will make recommendations and refer to the doctor. c. ADONs implemented weight monitoring process on 05/02/2011. d. RD or designee will audit weekly weights and interventions to assure compliance for 3 months. QA coordinator will monitor weight process to assure unplanned weight loss is addressed. e. Completed by 05/16/2011 			